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MEMORANDUM

January 3, 2017

To: House Committee on Energy and Commerce
Attention: [redacted]

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Subject: **CRS Responses to Health Insurance Exchange and Coverage Questions from the House Energy and Commerce Committee**

This memorandum provides answers to the five questions you posed to CRS. In some cases the questions you posed have been edited for clarity. Given that the topics covered in our answers are of general interest to Congress, the information included in our answers may be provided to other congressional requesters, or incorporated into other CRS products for general distribution. Your identity as a requester would not be disclosed in either case.

1. When was the 2017 Notice of Benefit and Payment Parameters released in draft form, finalized, and when did it take effect? When were the Notices of Benefit and Payment Parameters issued, finalized, and made effective each of the proceeding years?

In December 2012, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014*.[1] The proposed rule described how various ACA-related programs and requirements would be implemented when they became effective in 2014. For example, the proposed rule explained how CMS would assess a user fee on health insurance issuers that offered qualified health plans (QHPs) through federally-facilitated exchanges (FFEs).[2] The proposed rule was finalized in March 2013. CMS has issued a Notice of Benefit and Payment Parameters for each calendar year since 2014. The publication date of each

[1] 77 *Federal Register* 73118, December 7, 2012.

[2] A state can choose to establish its own state-based exchange (SBE). If a state opts not to, or if the Department of Health and Human Services (HHS) determines that the state is not in a position to administer its own exchange, then HHS will establish and administer the exchange in the state as a federally-facilitated exchange (FFE). There are varying levels of state involvement in FFEs. In many states with FFEs, the exchange is wholly operated and administered by HHS. In some cases, states may partner with HHS to establish and administer the exchange. For more details, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

proposed Notice is shown in **Table 1**, as is the publication date, effective date, and summary of each final Notice.

Table 1. Selected Information about Notices of Benefit and Payment Parameters

	Proposed Rule	Final Rule		
For Year	Publication Date	Publication Date	Effective Date	Summary from Preamble
2014	Dec. 7, 2012	Mar. 11, 2013	April 30, 2013	"This final rule provides detail and parameters related to: the risk adjustment, reinsurance, and risk corridors programs; cost-sharing reductions; user fees for Federally-facilitated Exchanges; advance payments of the premium tax credit; the Federally-facilitated Small Business Health Option Program; and the medical loss ratio program."
2015	Dec. 2, 2013	Mar. 11, 2014	May 12, 2014	"This final rule sets forth payment parameters and oversight provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges. It also provides additional standards with respect to composite premiums, privacy and security of personally identifiable information, the annual open enrollment period for 2015, the actuarial value calculator, the annual limitation in cost sharing for stand-alone dental plans, the meaningful difference standard for qualified health plans offered through a Federally-facilitated Exchange, patient safety standards for issuers of qualified health plans, and the Small Business Health Options Program."
2016	Nov. 26, 2014	Feb.27, 2015	Jan. 1, 2016	"This final rule sets forth payment parameters and provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges. It also finalizes additional standards for the individual market annual open enrollment period for the 2016 benefit year, essential health benefits, qualified health plans, network adequacy, quality improvement strategies, the Small Business Health Options Program, guaranteed availability, guaranteed renewability, minimum essential coverage, the rate review program, the medical loss ratio program, and other related topics."
2017	Dec. 2, 2015	Mar. 8, 2016	May 9, 2016	"This final rule sets forth payment parameters and provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost-sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges. It also provides additional amendments regarding the annual open enrollment period for the individual market for the 2017 and 2018 benefit years; essential health benefits; cost sharing; qualified health plans; Exchange consumer assistance programs; network adequacy; patient safety; the Small Business Health Options Program; stand-alone dental plans; third-party payments to qualified health plans; the definitions of large employer and small employer; fair health insurance premiums; student health insurance coverage; the rate review program; the medical loss ratio program; eligibility and enrollment; exemptions and appeals; and other related topics."

For Year	Proposed Rule: Publication Date	Final Rule: Publication Date	Final Rule: Effective Date	Final Rule: Summary from Preamble
2018	Sept. 6, 2016	Dec. 22, 2016	Jan. 17, 2017	"This final rule sets forth payment parameters and provisions related to the risk adjustment program; cost-sharing parameters and cost- sharing reductions; and user fees for Federally-facilitated Exchanges and State-based Exchanges on the Federal platform. It also provides additional guidance relating to standardized options; qualified health plans; consumer assistance tools; network adequacy; the Small Business Health Options Programs; stand-alone dental plans; fair health insurance premiums; guaranteed availability and guaranteed renewability; the medical loss ratio program; eligibility and enrollment; appeals; consumer-operated and oriented plans; special enrollment periods; and other related topics."

Sources: 77 *Federal Register* 73118, December 7, 2012; 78 *Federal Register* 15410, March 11, 2013; 78 *Federal Register* 72322, December 2, 2013; 79 *Federal Register* 13744, March 11, 2014; 79 *Federal Register* 70674, November 26, 2014; 80 *Federal Register* 10750, February 27, 2015; 80 *Federal Register* 75488, December 2, 2015; and 81 *Federal Register* 12204, March 8, 2016; 81 *Federal Register* 61455, September 6, 2016; 81 *Federal Register* 94058, December 22, 2016.

2. Please explain the process and timeframes for qualified health plans (QHPs) being approved to be sold through health insurance exchanges for benefit years 2017 and 2018. Please include steps and timeframes/dates for plan development, submission, review (including rate review), and CMS approval.

One function of a health insurance exchange is to certify health insurance plans as QHPs that can be offered through the exchange.[3] An exchange must certify QHPs to be offered through both its nongroup, or individual, market and its small group market.[4]

The entity administering an exchange sets and implements the exchange's QHP certification process. As the administrator of all FFEs, CMS sets the QHP certification process for all FFEs. The process is described each year in guidance issued by CMS.[5] CMS modifies aspects of the process from year to year, but in general the process starts each year in the spring prior to the benefit year in which the QHP is to be offered. CMS provides a deadline by which issuers must submit their initial QHP applications. Once that deadline passes, CMS and the issuers enter into a "review and revise" phase that lasts several months. During this phase CMS reviews the QHP applications, notifies applicants about needed corrections to the applications, and allows the applicants to revise their applications. In August of the year prior to the benefit year in which the QHP is to be offered, the QHP applications are generally expected to be finalized, and CMS reviews the final applications. In the fall, CMS asks issuers to validate the list of QHPs they intend to offer through FFEs, and CMS notifies issuers about preliminary certification of their QHPs. CMS will then review required documents submitted by the issuer and certify QHPs as appropriate. All of these activities are scheduled to be completed prior to the start of the exchange open enrollment period, which in recent years has been November 1.

[3] 42 U.S.C. § 18031(d)(4)(A).

[4] Small group plans are offered through the exchange's small business health options program (SHOP) exchange.

[5] Each year CMS describes the process in its annual letter to issuers that want to sell plans through an FFE.

The processing of collecting and reviewing information under the federal rate review program occurs concurrently with the QHP certification process.[6] Under the federal rate review program, all issuers offering plans in the nongroup and small-group markets are required to submit data and documentation regarding all rate increases. The federal rate review program applies to issuers that offer nongroup and small-group plans inside and outside of the exchanges. Issuers that propose unreasonable rate increases must also submit a justification for the increase to the Secretary of the Department of Health and Human Services (HHS) and the relevant state prior to implementation of the increase. Specifically, proposed rates with an increase of 10% or more are considered unreasonable and must be justified. States may propose state-specific thresholds (i.e., different from 10%), and CMS will determine whether the state may implement the proposed threshold.[7] (The ACA does not establish federal authority to deny implementation of a proposed rate increase, regardless of whether the increase meets the definition of unreasonable.)

If HHS determines that a state has an effective rate review system (i.e., the resources and authority to conduct rate reviews), then the state conducts the review under the federal rate review program. If a state does not have an effective rate review program, HHS conducts the review. As of April 8, 2016, 46 states and the District of Columbia had an effective rate review program in both markets, and four states relied on HHS to conduct review in both markets.[8]

Each year CMS issues guidance that provides the deadlines with which issuers must comply for submitting information about rate filings for the federal rate review program. As noted, the process occurs concurrently with the QHP certification process for FFEs. **Table 2** shows the timeline for both of these processes—QHP certification in FFEs and rate review—for benefit year 2017. **Table 3** shows the timelines for benefit year 2018. It should be noted that while both of these tables shows the timelines as outlined by CMS, in some cases states may have different deadlines for certain parts of either process with which issuers must comply.[9] Those state-specific deadlines are not included in Tables 2 or 3.

Table 2. Timeline for QHP Certification and Rate Review for the 2017 Benefit Year

As outlined by the Centers for Medicare & Medicaid Services (CMS)

Type of Activity	Activity	Date
QHP Certification[a]	Initial QHP application submission window	4/11/16 – 5/11/16
Rate Review	Submission deadline for all rate filing justifications for issuers in a state without an effective rate review program	5/11/16
QHP Certification	CMS reviews initial QHP applications as of 5/11/16	5/12/16 – 6/10/16
QHP Certification	CMS send first correction notice	6/15/16 – 6/16/16
QHP Certification	Deadline for submission of revised QHP data	6/30/16
QHP Certification	CMS reviews revised QHP data as of 6/30/16	7/1/16 – 8/2/16
Rate Review	Submission deadline for all rate filing justifications for issuers in a state with an effective rate review program	7/15/16

[6] The federal rate review program is codified at 42 U.S.C. § 300gg-94.

[7] For more details, see *State-Specific Threshold Proposals*, at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/sst.html.

[8] For more details, see *State Effective Rate Review Programs*, at https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/rate_review_fact_sheet.html.

[9] For more information about when states can set their own timelines or apply their own deadlines, see the source documentation for **Table 2** and **Table 3**.

Type of Activity	Activity	Date
Rate Review	Deadline for states with an effective rate review program to publicly post proposed rate increases subject to review	8/1/16
QHP Certification	CMS sends second correction notice	8/8/16 – 8/9/16
QHP Certification	Deadline for issuer submission of changes to QHP applications	8/23/16
Rate Review	Deadline for all rate filing justifications for QHPs to be in a final status	8/23/16
QHP Certification	CMS reviews final QHP data received as of 8/23/16	8/24/16 – 9/9/16
QHP Certification	States send CMS final plan recommendations	9/8/16
QHP Certification	CMS sends certification notices to issuers	9/15/16 – 9/16/16
QHP Certification	Issuers send agreements and plan list to CMS; final opportunity for issuers to withdraw QHPs from the certification process for the 2017 plan year	9/19/16 – 9/23/16
QHP Certification	CMS sends validation notice to issuers	10/3/16 – 10/4/16
Rate Review	All final rate increase information must be posted publicly	11/01/16
Open enrollment	Open enrollment period	11/01/16 – 1/31/17

Sources: All the QHP certification activities and associated dates are found in CMS, *2017 Letter to Issuers in the Federally-Facilitated Marketplaces*, February 29, 2016, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf. All the rate review activities and associated dates are found in the aforementioned source or CMS, *Bulletin: Timing of Submission and Posting of Rate Filing Justifications for the 2016 Filing Year for Single Risk Pool Coverage*, February 29, 2016, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-rate-filing-justification-bulletin-2-29-16.pdf.

Notes: For more information about the activities listed in the table, see the corresponding source document.

a. Issuers that want to continue to offer a QHP through a FFE must recertify their QHPs each year. In general, the recertification process is the same as the certification process.

Table 3. Timeline for QHP Certification and Rate Review for the 2018 Benefit Year

As outlined by the Centers for Medicare & Medicaid Services (CMS)

Type of Activity	Activity	Date
QHP Certification[a]	Initial QHP application submission window	4/5/17 – 5/3/17
Rate Review	Submission deadline for all rate filing justifications for issuers in a state without an effective rate review program	5/3/17
QHP Certification	CMS reviews initial QHP applications as of 5/3/17	5/4/17 – 6/5/17
QHP Certification	CMS sends issuers initial plan confirmation lists	5/12/17
QHP Certification	CMS send first correction notice	6/12/17 – 6/13/17
QHP Certification	Deadline for submission of revised QHP data	6/27/17
QHP Certification	CMS reviews revised QHP submission as of 6/27/17	6/28/17 – 7/28/17
Rate Review	Submission deadline for all rate filing justifications for issuers in a state with an effective rate review program	7/17/17
Rate Review	Change window closes for proposed rate filing justifications	7/25/17

Type of Activity	Activity	Date
Rate Review	Target date for making all initial proposed rate changes for coverage available for consumers to review on https://ratereview.healthcare.gov	8/1/17
Rate Review	Deadline for state with an effective rate review program to publicly post proposed rate increased subject to review	8/1/17
QHP Certification	CMS sends second correction notice	8/7/17 – 8/8/17
QHP Certification	Service area petition deadline	8/9/17
QHP Certification	Deadline for issuer submission of changes to QHP applications	8/21/17
Rate Review	Deadline for all rate filing justifications to be in a final status in the system used to capture rate filing information	8/21/16
QHP Certification	CMS reviews final QHP submission as of 8/21/17	8/22/17 – 9/5/17
QHP Certification	CMS sends final correction notices to issuers, with agreements for signature and plan lists for confirmation	9/11/17
QHP Certification	Issuers send signed agreements, confirmed plan lists, and final plan crosswalks to CMS	9/12/17 – 9/15/17
QHP Certification	Limited data correction window: outreach to issuer with CMS or state identified data errors; issuers submit correction; CMS reviews and finalizes data for open enrollment	9/12/17 – 10/13/17
QHP Certification	States send CMS final plan recommendations	9/15/17
QHP Certification	CMS send certification notices with countersigned Agreements and final plan lists to issuers	9/21/17 – 9/22/17
Rate Review	Target date for CMS to post all final rate changes for coverage on https://ratereview.healthcare.gov Target date for states with an effective rate review program to post final rate increase information for single risk pool coverage	11/1/17
	Open enrollment	11/1/17 – 1/31/18

Source: All the QHP certification activities and associated dates are found in CMS, *2018 Letter to Issuers in the Federally-facilitated Marketplaces*, December 16, 2016, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf. All the rate review activities and associated dates are found in the aforementioned source or CMS, *Key Dates for Calendar Year 2017: QHP Certification in the Federally-facilitated Marketplaces; Rate Review; Risk Adjustment and Reinsurance*, December 16, 2016, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Key-Dates-for-Calendar-Year-2017-12-16-16.pdf.

Notes: For more information about the activities listed in the table, see the corresponding source document.

a. Issuers that want to continue to offer a QHP through a FFE must recertify their QHPs each year. In general, the recertification process is the same as the certification process.

3. What is known about the scope of the increase in federal outlays for premium tax credits and cost-sharing subsidies (for coverage purchased through health insurance exchanges) in benefit year 2017 due to premium increases from benefit year 2016?

In March 2016, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimated that premium tax credits would cost the federal government $32 billion in 2016 and increase to

$43 billion in 2017.[10] CBO and JCT estimated that federal outlays for cost-sharing reductions would be $7 billion in 2016 and increase to $9 billion in 2017.[11]

CBO and JCT do not specify how different factors, such as premium increases from the previous benefit year, contribute to the increases in their estimates of federal outlays. However, in discussing premium tax credits and cost-sharing reductions, they note:

> Subsidies for insurance obtained through the health insurance marketplaces depend on the number of people who purchase such coverage, the reference premiums for the policies,[12] and certain characteristics of enrollees, such as family size and income.[13]

CBO and JCT estimate that total enrollment in exchanges will increase from 12 million to 15 million individuals between 2016 and 2017, and they expect to see an increase in the number of exchange enrollees with subsidized coverage, from 10 million in 2016 to 12 million in 2017.[14] CBO and JCT do not provide an estimate of how they expect the premiums for reference plans to change between 2016 and 2017, but over the 2017-2026 period they expect the average reference premium for 21- to 24-year-olds to grow by an average of 6% each year.[15] The agencies do not comment on whether or how they expect the characteristics of exchange enrollees to change between 2016 and 2017.

4. What is the total federal outlay for individuals enrolled in Exchanges who are eligible for premium tax credits and cost-sharing subsidies with incomes at or below 100% of federal poverty level (FPL)? Similarly, what is the outlay for such individuals with incomes at or below 200% FPL?

Available data about actual federal outlays for cost-sharing subsidies and premium tax credits are limited. The only data CRS was able to obtain on cost-sharing subsidies is federal outlays for fiscal years 2014, 2015, and 2016.[16] According to the IRS Budget Office, federal outlays for cost-sharing reductions were $2.1 billion in fiscal year 2014, $5.4 billion in fiscal year 2015, and $5.7 billion in fiscal year 2016.[17]

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[10] Congressional Budget Office (CBO), *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026*, March 2016, Table 2, at https://www.cbo.gov/publication/51385.

[11] Ibid.

[12] The reference premium is the premium for the second-lowest silver plan offered through an exchange in which an individual participates. The amount an eligible individual receives in premium tax credits is, in part, based on the individual's reference premium.

[13] Congressional Budget Office (CBO), *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026*, March 2016, p. 12, at https://www.cbo.gov/publication/51385.

[14] Congressional Budget Office (CBO), *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026*, March 2016, Table 1, at https://www.cbo.gov/publication/51385.

[15] CBO and JCT focus on the premiums for 21- to 24-year-olds because they are typically used as the basis for calculating premiums for other ages. CBO and JCT have previously estimated that premiums for reference plans would increase, on average, about 8% each year between 2016 and 2018. That estimate relied on CBO's March 2015 baseline, whereas the other estimates referenced in this section rely on CBO's March 2016 baseline. For more details about the estimates using the March 2015 baseline, see CBO, *Private Health Insurance Premiums and Federal Policy*, February 2016, at https://www.cbo.gov/publication/51130.

[16] In March 2016, CMS issued guidance about the cost-sharing subsidies, indicating the intent to "issue a report showing cost sharing reduction reconciliation payments and charges separately for each benefit year by June 30, 2016." CRS could not find such a report.

[17] Email from IRS Budget Office, November 10, 2016. The outlays for fiscal years 2015 and 2016 include payments for cost-sharing subsidies as well as payments to states that established Basic Health Programs (BHP). Section 1331 of the ACA provides that states may establish BHPs for certain low-income individuals in the state in lieu of those individuals obtaining coverage through the state's exchange. States that establish BHPs receives federal funding equal to 95% of the premium tax credit and (continued...)

The Internal Revenue Service (IRS) published its annual Statistics of Income (SOI) report for tax year 2014, which included preliminary data about premium tax credits.[18] For tax year 2014, approximately 3.1 million tax returns claimed the credits for a total of nearly $11.2 billion.[19] Tax return counts and associated costs were also provided by income band (**Table 4**).

Table 4. Premium Tax Credit by Size of Adjusted Gross Income for Tax Year 2014

Size of Adjusted Gross Income	Number of Returns	Total Premium Tax Credit	
		Number of Returns	Amount (in thousands of dollars)
No adjusted gross income	2,034,138	107,234	$591,587
$1 under $5,000	10,262,509	156,260	$685,322
$5,000 under $10,000	11,790,191	220,665	$848,284
$10,000 under $15,000	12,289,794	376,167	$1,389,217
$15,000 under $20,000	11,331,450	469,604	$1,609,039
$20,000 under $25,000	10,061,750	441,736	$1,448,668
$25,000 under $30,000	8,818,876	377,436	$1,311,535
$30,000 under $35,000	7,854,027	286,176	$950,667
$35,000 under $40,000	6,745,647	216,736	$714,893
$40,000 under $45,000	6,098,198	149,422	$524,928
$45,000 under $50,000	5,374,516	87,974	$365,593
$50,000 and over	55,945,480	215,209	$735,720
All returns, total	**148,606,578**	**3,104,620**	**$11,175,462**

Source: IRS, Statistics of Income Division, Publication 1304, Table 2.7, August 2016.

Notes: The data represent tax return information at the time of filing; therefore, the data do not incorporate corrections or amendments made to the tax returns at a later time.

The SOI data is not presented by FPL. As a point of comparison, the income level used to determine premium credit eligibility for one person with income at 100% FPL in 2014, living in one of the 48 contiguous states or Washington D.C., was $11,490; for 200% FPL it was $15,510. Income levels were higher for those living in Alaska or Hawaii, or for households with more than one person.[20]

(...continued)

cost-sharing subsidies that would have been provided to individuals covered under the BHP had they obtained coverage through the state's exchange.

[18] The data represent tax return information at the time of filing; therefore, the data do not incorporate corrections or amendments made to the tax returns at a later time. IRS, "Statistics of Income—2014 Individual Income Tax Returns," at https://www.irs.gov/pub/irs-soi/14inalcr.pdf.

[19] The report also included data about receipt of the tax credits in advance: approximately 3.4 million tax returns indicated receipt of advance payments totaling to almost $12 billion. The number of taxpayers who received advance payments exceeded the number who were eligible for the credits, indicating that some taxpayers received unauthorized credits. The IRS did not include an estimate of the number of taxpayers who received unauthorized credits the report. The data for advanced tax credits are not shown in **Table 4**.

[20] The poverty guidelines are updated annually, at the beginning of the year. However, premium tax credit calculations are based on the prior year's guidelines to provide individuals with timely information as they compare and enroll in exchange plans during the open enrollment period (which occurs prior to the beginning of the plan year). So, eligibility for tax credits in 2014 is based (continued...)

The premium tax credit data in **Table 4** is shown by adjusted gross income (AGI), but eligibility for and amount of the premium tax credit is based, in part, on the modified adjusted gross income (MAGI) of the individual (or family) seeking exchange coverage.[21] Also, the data in **Table 4** is for tax returns. Given this, it is not possible to discern from this data how many people (as opposed to tax returns) actually received the tax credits.

5. What is known (from CBO, etc.) about how the individual mandate has affected outlays for the Medicaid program and financial subsidies for coverage purchased through the Exchanges?

In December 2016, CBO and JCT issued a report, *Options for Reducing the Deficit: 2017 to 2026.*[22] One of the options discussed in the report is stand-alone repeal of the individual mandate (i.e., repeal of the mandate while other ACA provisions, such as the premium tax credits and Medicaid expansion, remain in place). Their analysis of repeal of the individual mandate is not the same as an analysis of the effects of implementing the mandate, but their analysis does approximate the role the mandate plays in encouraging take up of Medicaid and subsidized exchange coverage and thus affecting outlays for those programs.

According to the report, if the mandate were repealed beginning in January 2018, CBO and JCT estimate that it would lower the federal budget deficit by $416 billion, from 2018 to 2026. CBO and JCT conclude that while repealing the mandate would lead to loss of revenue that would have come from penalties for individuals violating the mandate, the loss would be offset from even greater savings due to reduced federal outlays for health coverage. The agencies estimate that outlays would be reduced by $381 billion, from 2018 to 2026. The primary source of the outlay reduction would be Medicaid (approximately $279 billion); the secondary source would be the premium tax credits and cost-sharing subsidies provided to eligible individuals enrolled in exchange coverage (approximately $96 billion). The remaining amount (approximately $6 billion) would be due to other effects of the repeal. CBO and JCT estimate that repealing the mandate would mean that by 2026, seven million fewer individuals would have Medicaid coverage, six million fewer individuals would have nongroup, or individual, coverage, and two million fewer individuals would have employer-sponsored coverage.

(...continued)

on the 2013 poverty guidelines. Those guidelines are available at https://aspe.hhs.gov/2013-poverty-guidelines#guidelines.

[21] For a discussion of how modified adjusted gross income differs from adjusted gross income, see CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*.

[22] CBO, *Options for Reducing the Deficit: 2017 to 2026*, Dec. 8, 2016, at https://www.cbo.gov/publication/52142.